Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: P MATTHEW ONEAL ON BEHALF OF CENTRAL TEXAS MEDICAL CENTER 6514 MCNEIL DRIVE BLDG 2 SUITE 201 AUSTIN TX 78729	MFDR Tracking #: M4-09-7993-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE COMPANY Box #: 54	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "The total amount billed was $55,842.69…Texas Mutual Insurance Company…has paid nothing to date, and has denied the claim for timely filing. When my client contacted TMIC and TMIC alleged that the claim was not processed since box 71 of the UB-04 was not completed…the claim was submitted timely within 95 days on at least two and apparently three occasions. However, TMIC has still maintained its denial on the alleged basis that Box 71 of the UB was not completed. Furthermore, the claim as originally submitted is complete and a clean claim by all accounts. Box 71, which identifies a PPS Code (prospective payment code), is not a required element on the bill. It is not an ICD-9 or procedure code, and TMIC was perfectly capable of identifying the PPS Code that is otherwise set for in Box 71. Further, neither CMS or DWC require completing the box as a requirement for a clean and timely claim…based on available documentation, the hospital provided TMIC with a corrected UB with the PPS Code being provided."

Amount in Dispute: $38,350.75

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Texas Mutual denied the treatment in this dispute due to untimely filing. The requestor submitted its bill to Texas Mutual where it was received 9/22/08 and 11/24/08. The bill was determined to be incomplete and returned 9/29/08 and 12/02/08 along with a letter stating Box 71 was either missing or invalid… Texas Mutual does not deny that the requestor submitted its medical bill to this insurance carrier where it was received 9/22/08 and 11/24/08; however, what the requestor sent was an incomplete bill. The requestor did not send the complete medical bill to Texas Mutual until 1/5/09, which by that time the filing deadline had lapsed. Texas Mutual audited the billed charges denying payment on the basis of untimely submission of the bill. The Labor Code at section 408.027 and DWC Rule 133.20 require a health carrier provider to submit a medical bill by the 95th day following the date of service or forfeit the right to reimbursement. The 95th day following the date of service, consistent with Rule 133.20, passed on 11/25/2008. To be compliant with DWC Rule 133.20 the complainant had until 11/25/2008 to submit its bill. Records submitted do not reflect that the requestor filed its complete services within the 95th day after the date of service to this insurance carrier; therefore, the requestor was not compliant with DWC Rule 133.20. Given the above, Texas Mutual believes no payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
08/15/2008 through 08/22/2008	Inpatient Hospital Services	$26,780.74 (DRG 329) (IPPS) x 143% = $38,296.46 (MAR) - $0.00 (Total Paid by Respondent) = $38,296.46 (Amount Due Requestor)	$38,350.75	$38,296.46
			Total Due:	$38,296.46

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code, Section §408.027(a), titled *Payment of Health Care Provider*, effective September 1, 2007 states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."
2. Texas Labor Code, Section §408.0272(b), titled *Certain Exceptions For Untimely Submission of Claim*, effective September 1, 2005, states "Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if: (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.207(a), erroneously filed for reimbursement with: (A) an insurer that issues a policy of group accident and health insurance under which the injured is a covered insured; (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider."
3. Division rule at 28 TAC §133.2(2), effective May 2, 2006, defines a complete medical bill as "A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats), or as specified for electronic medical bills in §133.500 of this chapter (relating to Electronic Formats for Electronic Medical Bill Processing).
4. Division rule at 28 TAC §133.20(b), effective January 29, 2009, states that "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A)-(H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation."
5. Division rule at 28 TAC § 102.4(h), titled *General Rules for Non-Commission Communication*, effective May 1, 2005 states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:(1) the date received, if sent by fax, personal delivery or electronic transmission; or (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
6. Division rule at 28 TAC §133.20(c), effective January 29, 2009 states that "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."
7. Division rule at 28 TAC §133.20(f), effective January 29, 2009, states "Health care providers shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills)."
8. Division rule at 28 TAC §133.20(g), effective January 29, 2009, states "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier."
9. Division rule at 28 TAC §133.200(a)(1), effective May 2, 2006, states that "Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill."
10. Division rule at 28 TAC §133.250(a), titled *Reconsideration for Payment of Medical Bills,* effective May 2, 2006, states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action."
11. Division rule at 28 TAC §133.307(c)(1), titled *MDR of Fee Disputes*, effective May 25, 2008, requires "A requestor

shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request."

12. Division rule at 28 TAC §134.404, titled *Hospital Facility Fee Guideline – Inpatient*, effective March 1, 2008 sets out reimbursement guidelines for inpatient hospitalizations.

13. 28 Texas Administrative Code §21.2803(b) titled *Submission of Clean Claims*, effective February 12, 2007 states "Required data form and data elements for institutional provides for claims filed or re-filed on or after July 18, 2007 (A) provider's name, address, and telephone number (UB-04, field 1); is required; (B) patient control number (UB-04, field 3a) is required; (C) type of bill code (UB-04, field 4) is required and shall include a "7" in the fourth position if the claim is a corrected claim; (D) provider's federal tax ID number (UB-04, field 5) is required; (E) statement period (beginning and ending date of claim period) (UB-04, field 6) is required; (F) patient's name (UB-04, field 8a) is required; (G) patient's address (UB-04, field 9a – 9e) is required; (H) patient date of birth (UB-04, field 10) is required; (I) patient gender (UB-04, field 11) is required; (J) date of admission (UB-04, field 12) is required for admissions, observation stays, and emergency room care; (K) admission hour (UB-04, field 13) is required for admissions, observation stays, and emergency room care; (L) type of admission (e.g. emergency, urgent, elective, newborn) (UB-04, field 14) is required for admissions; (M) source of admission code (UB-04, field 15) is required; (NO) discharge hour (UB-04, field 16) is required for admissions, outpatient surgeries, or observation stays; (O) patient-status-at-discharge code (UB-04, field 17) is required for admissions, observation stays, and emergency room care; (P) condition codes (UB-04, fields 18-28) are required if the CMS UB-04 manual contains a condition code appropriate to the patient's condition; (Q) occurrence codes and dates (UB-04, fields 31 – 34) are required if the CMS UB-04 manual contains an occurrence code appropriate to the patient's condition; (R) occurrence span codes and from and through dates (UB-04, fields 35 and 36) are required if the CMS UB-04 manual contains an occurrence span code appropriate to the patient's condition; (S) value code and amounts (UB-04, fields 39 - 41) are required for inpatient admissions. If no value codes are applicable to the inpatient admission, the provider may enter value code 01; (T) revenue code (UB-04, field 42) is required; (U) revenue description (UB-04, field 43) is required; (V) HCPCS/Rates (UB-04, field 44) are required if Medicare is a primary or secondary payor; (W) service date (UB-04, field 45) is required if the claim is for outpatient services; (X) date bill submitted (UB-04, field 45, line 23) is required; (Y) units of service (UB-04, field 46) are required; (Z) total charge (UB-04, field 47) is required; (AA) HMO or preferred provider carrier name (UB-04, field 50) is required: (BB) prior payments-payor (UB-04, field 54) are required if payments have been made to the physician or provider by a primary plan as required by subsection (D) of this section; (CC) for claims field or re-field on or after May 23, 2008, the NPI number of the billing provider (UB-04, field 56) is required if the billing provider is eligible for an NPI number; (DD) other provider number (UB-04, field 57) is required if the HMO or preferred provider carrier, prior to June 17, 2003, required provider numbers and gave notice of that requirement to physicians and providers; (EE) subscriber's name (UB-04, field 58) is required if shown on the patient's ID card; (FF) patient's relationship to subscriber (UB-04, field 59) is required; (GG) patient's/subscriber's certificate number; health claim number, ID number (UB-04,field 60) is required if shown on the patient's ID card; (HH) insurance group number (UB-04, field 62) is required if a group number is shown on the patient's ID card; (II) verification number (UB-04, field 63) is required if services have been verified pursuant to §19.1724 of this title. If no verification has been provided, treatment authorization codes (UB-04, field 63) are required when authorization is required and granted; (JJ) principal diagnosis code (UB-04, field 67) is required; (KK) diagnoses codes other than principal diagnosis code (UB-04, fields 67A – 67Q) are required if there are diagnoses other than the principal diagnosis; (LL) admitting diagnosis code (UB-04, field 69) is required; (MM) principal procedure code (UB-04, field 74) is required if the patient has undergone an inpatient or outpatient surgical procedure; (NN) other procedure codes (UB-04, fields 74 – 74e) are required as an extension of subparagraph (MM) of this paragraph if additional surgical procedures were performed; (OO) attending physician NPI number (UB-04, field 76) is required on or after May 23, 2008, if attending physician is eligible for an NPI number; and (PP) attending physician ID (UB-04, field 76, qualifier portion) is required."

14. The services in dispute were reduced/denied by the respondent with the following reason codes:

Return Letter dated 12/02/2008

- *** –Your medical bill was not processed and is being returned for the following reason(s): The following required fields are either missing or invalid. Box #71. The following Texas Department of Insurance Division of Workers' Compensation rules direct proper completion and submission of medical bills: Rule 133.1, Rule 133.300, Rule 133.304, Rule 134.202, Rule 134.801, Rule 134.800. For Date of Service 5/2/06 and beyond, Rule 133.1, Rule 133.10, Rule 133.20, Rule 133.200, Rule 133.210, Rule 133.250, Rule 133.280.

Explanation of benefits dated 1/16/2009

- CAC-29 – The time limit for filing has expired.
- 731 – 134.801 & 133.20 provider shall not submit a medical bill later than the 95th day after the date of service for service on or after 9/1/05.

Return Letter dated 04/23/2009

- *** –Your medical bill was not processed and is being returned for the following reason(s): Duplicate Appeal – More than one request for reconsideration has been received for the above referenced claim and date of service.

Only one request has been processed. If you have not received an explanation of benefits, please contact our office at 1(800)859-5995. The following required fields are either missing or invalid. Box #71. The following Texas Department of Insurance Division of Workers' Compensation rules direct proper completion and submission of medical bills: Rule 133.1, Rule 133.300, Rule 133.304, Rule 134.202, Rule 134.801, Rule 134.800. For Date of Service 5/2/06 and beyond, Rule 133.1, Rule 133.10, Rule 133.20, Rule 133.200, Rule 133.210, Rule 133.250, Rule 133.280.

15. The Division finds that the requestor has supported their position that the bills were submitted timely and reimbursement per Division rule at 28 TAC. §134.404 is recommended for the disputed services.

Issues

1. Did the health care provider submit a complete claim to the insurance carrier?
2. Did the insurance carrier meet the requirements of Division rule at 28 TAC §133.200(a)(1)?
3. Did the health care provider timely submit the claim to the insurance carrier?
4. Is the requestor entitled to additional reimbursement in accordance with Division rule at 28 TAC §134.404?

Findings

1. In a letter dated 12/2/2008, the insurance carrier returned as submitted claim for the disputed services as incomplete, stating "Your medical bill was not processed and is being returned for the following reason(s): The following required fields are either missing or invalid. Box #71." Division rule at 28 TAC §133.2(2), effective May 2, 2006, defines a complete medical bill as "A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats)." Division rule at 28 TAC §133.10(a) states that "Health care providers shall submit medical bills for payment: (1) on standard forms used by the Centers for Medicare and Medicaid Services (CMS)" The health care provider submitted a paper bill on a CMS form UB-04. Per 28 Texas Administrative Code §21.2803(b) titled *Submission of Clean Claims*, effective February 12, 2007, review of the required data form and data elements for institutional provides for claims filed or re-filed on or after July 18, 2007 finds that field 71 is not a required field. Review of the *INSTRUCTIONS FOR COMPLETING THE UB-04* submitted by the requestor finds that field 71 is not listed as a required field. Review of the information submitted by the respondent finds no documentation to support the respondent's position that field 71 is a required field. The Division therefore finds that the health care provider submitted a complete claim to the insurance carrier in accordance with Division rule at 28 TAC. §133.2(2).

2. Division rule at 28 TAC §133.200(a)(1), effective May 2, 2006, states that "Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill." The respondent returned a complete medical bill to the health care provider in a letter dated September 29, 2008, which states that "Your medical bill was not processed and is being returned for the following reason(s): The following required files are either missing or invalid: Please refer to the attached billing form instruction sheet. Box # 71…" The respondent did not submit documentation to support that the bill was a duplicate bill. The Division therefore finds that the insurance carrier has not met the requirements of §133.200(a)(1).

3. The respondent denied disputed services with reason codes CAC-29 – "The time limit for filing has expired," and 731 – "134.801 & 133.20 provider shall not submit a medical bill later than the 95th day after the date of service for service on or after 9/1/05." The respondent's position statement asserts that "The requestor submitted its bill to Texas Mutual where it was received 9/22/08 and 11/24/08. The bill was determined to be incomplete and returned 9/29/08 and 12/02/08 along with a letter stating Box 71 was either missing or invalid… Texas Mutual does not deny that the requestor submitted its medical bill to this insurance carrier where it was received 9/22/08 and 11/24/08; however, what the requestor sent was an incomplete bill." The requestor acknowledges receipt of the medical bill on 9/22/08. The dates of service were 8/15/2008-8/22/2008. The Division finds that a complete claim was received by the insurance carrier not later than the 95th day after the date on which the health care services were provided to the injured employee. The respondent's denial reasons are not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

4. Division rule at 28 TAC §134.404(e) states, in pertinent part, that "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"

   Pursuant to Division rule at 28 TAC §134.404(f), "The reimbursement calculation used for establishing the MAR shall

be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 143 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:

(1) No documentation was found to support any contractual agreement between the parties to this dispute;

(2) MAR can be established for these services; and

(3) No documentation was found to support that the provider requested separate reimbursement for implantables with the billing.

Consequently, reimbursement will be calculated in accordance with Division rule at 28 TAC §134.404(f)(1)(A) as follows: DRG 329 – the Medicare facility specific amount including any outlier payment is $26,780.74 X 143% = $38,296.46. This amount less the amount previously paid by the respondent of $0.00 yields an amount due to the requestor of $38,296.46. This amount is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $38,296.46.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $38,296.46 reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $38,296.46 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.130, due within 30 days of receipt of the Order.

		08/31/2011
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		08/31/2011
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.